~~(2) ALL MEMBERSHIP ENROLLMENT MATERIALS SHALL CLEARLY INDICATE THE OFFICE, INCLUDING THE TELEPHONE NUMBER AND THE PROCESS FOR FILING A COMPLAINT, WITHIN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR THE ADMINISTRATION THAT IS RESPONSIBLE FOR RECEIVING AND RESPONDING TO ENROLLEE'S COMPLAINTS CONCERNING CARRIERS.~~

~~(H) (1) A CARRIER THAT TERMINATES A PARTICIPATING PROVIDER FOR REASONS OTHER THAN PROFESSIONAL COMPETENCE SHALL CONTINUE TO REIMBURSE THE PROVIDER FOR A PERIOD OF AT LEAST 60 DAYS FOR THE PROVIDER'S SERVICES TO THE CARRIER'S ENROLLEES WHO ELECT TO CONTINUE WITH THE PROVIDER.~~

~~(2) REIMBURSEMENT UNDER THIS SUBSECTION SHALL BE THE LESSER OF:~~

~~(I) THE RATE USED BY THE CARRIER TO REIMBURSE NONPARTICIPATING PROVIDERS; OR~~

~~(II) THE USUAL AND CUSTOMARY RATE OF THE PROVIDER.~~

~~657.~~

~~(a) If a preferred provider insurance policy offered by an insurer provides benefits for any service that is within the lawful scope of practice of a health care provider licensed under the Health Occupations Article, any insured covered by the preferred provider insurance policy shall be entitled to receive the benefits for that service either through direct payments to the provider or to reimbursement to the insured.~~

~~(b) (1) A preferred provider insurance policy offered by an insurer under this subtitle shall provide for payment of services rendered by nonpreferred providers as provided under this section.~~

~~(2) UNLESS THE INSURER DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER THAT AN ALTERNATIVE LEVEL OF PAYMENT IS MORE APPROPRIATE UNDER THE CIRCUMSTANCES, AN INSURER SHALL REIMBURSE A PHARMACY PROVIDER, AFTER ALL DEDUCTIBLE AND COPAYMENT PROVISIONS HAVE BEEN APPLIED, IN THE FOLLOWING MANNER:~~

~~(I) EITHER THE RATE OF REIMBURSEMENT TO A PREFERRED PROVIDER FOR THE COST OF THE DRUG PRODUCT OR THE CURRENT MARYLAND MEDICAL ASSISTANCE PROGRAM'S FORMULA FOR THE CALCULATION OF THE COST OF THE DRUG PRODUCT; AND~~

~~(II) A DISPENSING FEE IN ACCORDANCE WITH PARAGRAPH (3) OF THIS SUBSECTION.~~

~~[(2)](3) [Unless] EXCEPT AS PROVIDED IN PARAGRAPH (4) OF THIS SUBSECTION, UNLESS the insurer demonstrates to the satisfaction of the Insurance Commissioner that an alternative level of payment is more appropriate under the circumstances, aggregate payments in any full calendar year made under this paragraph to nonpreferred providers after all deductible and copayment provisions have been applied~~